Abstract: Background. Community ambulation is an important element of a rehabilitation training programme and its achievement is a goal shared by rehabilitation professionals and clients. The factors that influence a physiotherapist's or health professionals decision making around the preparation of a client for community ambulation and the factors that influence a client's decision to return to walking in their community are unclear. Objective. To review the available literature about the factors that have influenced the reasoning and decision making of rehabilitation therapists and clients around the topic of ambulation in the community. Method. Three separate searches of the available literature were undertaken using Ovid, Cinahl, ProQuest, Medline and Ebscohost databases. Databases were searched from 1966 to October 2006. The first search explored the literature for factors that influence the clinical reasoning of rehabilitation therapists. The second search explored the literature for factors that influence client's decision to ambulate in the community. A third search was undertaken to explore the literature for the demands of community ambulation in rural communities. Results. Very few studies were found that explored community ambulation in the context of clinical reasoning and decision making, the facilitators and barriers to a clients return to ambulation in their community or the demands of ambulation in a rural community. Conclusion. Consideration of the environment is key to the successful return to walking in the community of clients with mobility problems yet little literature has been found to guide physiotherapist's decision making about preparing a clients to return to walking in the community. An individual's participation in their society is also a result of the interaction between their personal characteristics and his or her environment. The influence of these characteristics may vary from one individual to another yet the factors that influence a person's decision to return to walking in their community after stroke remain unclear.

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Abstract

Background. Community ambulation is an important element of a rehabilitation training programme and its achievement is a goal shared by rehabilitation professionals and clients. The factors that influence a physiotherapist’s or health professionals decision making around the preparation of a client for community ambulation and the factors that influence a client’s decision to return to walking in their community are unclear.

Objective. To review the available literature about the factors that have influenced the reasoning and decision making of rehabilitation therapists and clients around the topic of ambulation in the community.

Method. Three separate searches of the available literature were undertaken using Ovid, Cinahl, ProQuest and Ebscohost databases. Databases were searched from 1966 to October 2006. The first search explored the literature for factors that influence the clinical reasoning of rehabilitation therapists. The second search explored the literature for factors that influence client’s decision to ambulate in the community. A third search was undertaken to explore the literature for the demands of community ambulation in rural communities.

Results. Very few studies were found that explored community ambulation in the context of clinical reasoning and decision making, the facilitators and barriers to a clients return to ambulation in their community and the demands of ambulation in a rural community

Conclusion. Consideration of the environment is key to the successful return to walking in the community of clients with mobility problems yet little literature has been found to guide physiotherapist’s decision making about preparing a clients to return to walking in the community. An individual’s participation in their society is
also a result of the interaction between their personal characteristics and his or her environment. The influence of these characteristics may vary from one individual to another yet the factors that influence a person’s decision to return to walking in their community after stroke remain unclear.

*Key Words* qualitative, community ambulation, decision making, clinical reasoning barriers, facilitators, perceptions, rural, gait, client.
Community ambulation: influences on therapists and clients reasoning and decision making

Introduction

The relationships between the domains of the International Classification of Functioning and Disability (ICF) model [1] highlight the many potential influences on a therapists decision making in the clinical setting and a clients response to a disease process and potential return to participation in the their community. [2] There are intuitive and subconscious factors that interact with the clinician’s theoretical knowledge and which assist decision making in the development of a suitable treatment plan for a client.[3] To optimize community ambulation it is important to understand more fully the factors that can influence the decision making of physiotherapists and other rehabilitation practitioners as they work with clients from diverse social, cultural and environmental backgrounds. Equally, the links between the domains of the ICF model of disability [1] also highlight the influences on a client that will affect their participation in the community. An awareness of these influences from the client’s perspective can inform community ambulation preparation.

The following is a review of the literature of the factors that have influenced the reasoning and decision making of rehabilitation practitioners and clients around the topic of community ambulation. For the purpose of this review community ambulation has been defined as walking in the community to pursue recreational, social or employment goals.
Method

To explore the available literature a search was conducted using Ovid, Cinahl, ProQuest, Ebscohost and Medline databases in the English language literature. Databases were searched from 1966 to October 2006. This time frame was selected as the earliest period from which electronic sources provide access to literature and when postgraduate studies were nearing completion. Articles available as full text in the English language qualitative and quantitative literature using adult human participants were included. Articles that included paediatric populations, and motorized or wheelchair assisted mobility methods were excluded. The primary author critiqued articles found for inclusion in the review.

Three primary searches were conducted. The first search explored the literature for factors that influence reasoning and decision making in rehabilitation practice around the activity of ambulation in the community. For the first search, terms such as clinical reasoning, decision making, theory, practice, physioth$, physical therapy, rehabilitation, neurolog$, community, outside, ambulation, mobility, walk$ and gait were used. Articles on decision making around gait retraining in the acute care setting were excluded.

The second search focused on literature that explored the client’s perception of factors that they perceive facilitate or are obstacles to their ability to ambulate in their community. The specific search terms used included client, patient, perception, participation, quality of life, aged, disability, barriers, facilitators, older pedestrians, stroke, function$ community ambulation, walk$, mobility, gait impairment and
environ$. Articles that explored facilitators or barriers to walking as a means of physical activity or fitness were excluded.

A third search was conducted to explore the literature for community ambulation requirements in rural communities. Terms such as rural, rural health, regional, walk$, community ambulation, mobility disability, ambulat$, function$, evaluat$ and isolation were used.

The following section discusses literature found from the first search that explored factors that influence reasoning and decision making in rehabilitation practice around the activity of community ambulation. For the purpose of this review community ambulation has been defined as walking in the community to destinations significant for participation in activities that fulfil quality of life.

**Search One Results**

Factors that influence reasoning and decision making in rehabilitation practice around the activity of ambulation in the community

There is increasing interest in the clinical reasoning and decision making processes of practitioners, the use of evidenced based practice by physiotherapists and other therapists’ and the perspectives and philosophical approaches that therapists use to guide their clinical practice in a range of settings [3,4,5,6,7]. Within the various health professions there has been a strong emphasis on developing a scientific and robust theoretical approach to underpin rehabilitation practice. The two theoretical approaches currently predominant are Neuro-facilitation [8] and Motor Relearning [9] and research has been undertaken to gain consensus on how these approaches
influence current rehabilitation practice in Australia and internationally.[6,7,10]. Both approaches emphasise the importance of training clients to walk on a variety of terrains and in different environments.

Only one (1) article was found that specifically explored clinicians’ views on the elements of the external environment that were important when retraining a clients community ambulation skills. [11] In this study 15 highly experienced rehabilitation physiotherapists who practiced in metropolitan hospitals were interviewed about the physical elements of the environment inside and outside the home that they felt were critical in facilitating client independence in community ambulation and the abilities that clients should possess in order to access their community. The activities that these physiotherapists felt were significant for successful community ambulation were traversing different terrains such as steps and gutters, negotiating obstacles, changing velocity and carrying objects. A number of other activities were seen as important which only served to highlight the physiotherapist’s perception of the skills complexity required for a client to walk safely and effectively in the community.

Discussion
From the literature review it is evident that there is a paucity of information available that can inform about decision-making in rehabilitation therapists practice around the topic of community ambulation. The literature found has indicated that therapists identify a number of challenges such as negotiating steps or walking at speed that clients must accomplish in order to ambulate in their community. There are no articles that discuss community ambulation in the context of rural or regional practice internationally or in Australia.
Clients' perception of the factors that facilitate or are obstacles to their ability to walk in their community

The environmental and personal domains of the ICF model enunciate the client’s perspective and situation in maximizing and maintaining health. In order to further understand the client’s perspective of ambulation in the community, a literature review was conducted to find material that captured research in this area. The following is a discussion of the articles found. For the purpose of the reader, this section has been divided into research using health aged participants and research whose participants had mobility impairments.

Facilitators or Obstacles to Community Ambulation in Healthy Aged Individuals

A number of articles in the literature explored the perceived and objectively determined environmental attributes that are associated with walking as a health-related physical activity in healthy individuals and the role of mobility restrictions in contributing to loneliness and a poorer quality of life for the older person. [12, 13, 14, 15]. Whilst these articles indicate that there are a range of attributes including the aesthetics of the walking environment, safety, the opportunity for social interaction, traffic levels and weather that will influence walking for exercise, it is still unclear of the impact of the specific features of the environment or personal considerations on ambulation in the community to get to and from specific locations.

Ten (10) studies were found that sought to determine environmental barriers to community ambulation. Three were excluded. One study did not indicate the mobility
status of the participants[10] and the other was an instrument validation study [11] The third study examined the retest reliability and validity of a self report measure of mobility disability as compared with observed mobility self reports on ADL tasks and performance based measures of gait and balance. This study however did not report on the specific barriers and facilitators identified by the participants.[16]

There were eight (8) studies in total found that sought to determine clients perceptions on factors that would influence ambulation in their community to complete specific tasks. Three (3) studies [16, 17, 18 ] included participants who were described as healthy older adults. Five (5) studies included participants who had mobility problems as a result of stroke. [20, 21, 22, 23, 24]

A study of 54 healthy older adults in Seattle (Canada) Shumway-Cook et. al. [16] observed participants behaviour whilst walking in the community on six occasions to locations such as the grocery store or health service. The primary focus of this study was to establish a correlation between what an individual self reports as limiting community ambulation using a questionnaire and what a clinician observes. Participants were also asked to complete a questionnaire (Environmental Analysis of Mobility Questionnaire) that explored the effects of the physical environment on their community ambulation. The impact of the environment was evaluated by participants recording the number of times they encountered a specific challenge and the avoidance strategies used. Features of the physical environment were grouped according to the eight dimensions of the environment [19], all of which were captured in the questionnaire. The results indicated that client self-report, observation by clinicians and the use of objective clinical evaluations of walking ability such as timed
walking tasks or the Berg Balance Test are reasonable methods for detecting specific mobility problems in a healthy older population.

A qualitative exploratory study asked 13 seniors to take photographs of barriers and facilitators to walking in their community of Ottawa, Canada. [17] Focus groups with 22 seniors then used the photographs to discuss the physical barriers that made walking in the community hazardous. Hazards linked to traffic and falls risk were identified as significant barriers, but if convenient and hazard free walkways were made available community connectivity, as reflected in the ease with which the individuals engaged with their community, could still exist. This finding has been reaffirmed in other studies that have evaluated the environmental factors that are associated with the uptake of and ongoing participation in walking as a form of physical activity [12,13,15] and the personal factors associated with independence and a sense of control.[14,18] The conclusion is that communities that are “activity friendly” and designed with appropriate walkways encourage individuals to walk in the community but the specific environmental hazards that can reduce confidence to participate in the community were not accounted for.

In another qualitative study Locket et. al. [18] explored the limitations to community ambulation for a group of 23 older women living in their community. For the clients interviewed community ambulation was meaningful to their ability to fulfill social, recreational and leisure needs independently and freely but was influenced by personal factors such as their health status and ability to drive and environmental factors such as traffic levels and access to public transport. Determination of risk when walking in the community or using public transport was also significant and
covered both personal and environmental factors and included the risk of interaction with dangerous people or the risk of injury due to weather conditions. This study highlighted the need to understand the range of perceived risks that can influence an individual’s community ambulation. By appreciating the risks perceived for a task that contributes significantly to quality of life steps can then be taken to reduce the risks when preparing clients for a return to community ambulation.

Community ambulation in a rehabilitation population

There were five studies found [20,21,22,23,24] that specifically explored the perceptions of clients with mobility problems as a result of stroke, about the environmental or personal factors that could influence their decision to resume ambulation in their community.

The studies found have been conducted in Canada, US, UK and one study in NZ.

A summary of these studies is provided in Table 1. The studies have been evaluated against the domains of the ICF.

[Insert table one about here]

A multi centre New Zealand observational study [20] attempted to assess how important community ambulation was to stroke survivors and to determine a correlation between the uptake of community ambulation and commonly used mobility measures. One hundred and fifteen stroke survivors were asked to complete 4 standardized mobility measures. These measures included the Functional
Ambulation Classification (FAC), Rivermead Mobility Index (RMI), 10 metre timed
walk test, and a walking endurance test on a treadmill over a distance of 300 metres.
Participants were also asked to complete a 6-item questionnaire self-reporting on the
importance of walking in the community (Q1), locations traveled to (Q2), distances
walked (Q3), the use of aids (Q4) and their level of dependency (Q5). This study
concluded that whilst a majority of the clients considered walking in the community
important (93%) and scored highly on the mobility scores (FAC-mean of 5.5, RMI-
mean of 12.4, gait speed-mean of 56.6 m/min and distance walked -mean of 168.4
metres) at least 1/3 of the cohort of 115 subjects did not go out into the community
unsupervised and those who did were reluctant or unable to access public transport
and relied on carers to accompany them outside the home. However, some
participants who scored poorly on gait measures continued to access their community.
This study raised two questions with respect to community ambulation. Firstly, why
does the achievement of good mobility outcomes such as those indicated, not
necessarily reflect a return to activities that include independent community
ambulation and secondly, for those participants with lower functional status, what
facilitated a return to walking in their community? This study highlights the
inadequacy of current measurement tools in reflecting a client’s ability to resume
walking in their community. For example consider the difference between the 10m
timed walk test to determine gait velocity and walking 300 metres to replicate the
speed and endurance requirements of community ambulation. Further it alludes to the
impact of the personal dimensions on the decision to walk in one’s community.

The implementation of an occupational therapy home based programme to improve
outdoor mobility after stroke was evaluated in the London area. [21] One hundred and
sixty eight clients were posted questionnaires at four and ten months post stroke. The intervention in this study that particularly addressed the activity of walking in the community included the client being accompanied walking outside by the researcher until confidence was restored. Other interventions to enhance community ambulation included client education on transport services, provision of aids and advice on community supports. The outcome used was number of journeys into the community. This study showed that the mobility scores of the Nottingham Extended Activities of Daily Living Index were significantly improved in those people who received the intervention compared to those who did not. No significant differences were recorded at the 10-month interval but it was unclear whether those receiving the intervention reduced their community ambulation or the control group increased their community ambulation. This study did not address limitations to community ambulation based on the functional requirements of walking in the community such as walking distance, terrain changes such as steps or stairs or other barriers. The provision of physical support to aid confidence however suggests that addressing confidence in any form is a potential facilitator to a return to walking in the community.

A Canadian metropolitan study explored the role of environmental and social factors in determining the degree of handicap in a group of stroke survivors 6 months after discharge from rehabilitation. [22] Fifty-one clients were asked to complete questionnaires that captured personal factors such as age and gender and environmental elements that were perceived as barriers or facilitators to accomplishment in daily activities and social roles. Environmental factors were evaluated using an 84-item questionnaire (Measure of the Quality of the Environment, Version 1.0). [2] The categories were support and attitudes, income and jobs,
governmental and public services, physical environment and accessibility, technology and equal opportunity. There was no discussion in this paper of the particular elements within the environment that facilitated or restricted participation; however the conclusion drawn is that environmental factors that create barriers to participation reduce quality of life. This finding reinforces the interaction between the environment and the personal factors as embodied in current and emerging models of disablement but does not add to our knowledge of unique features in the environment that can influence the activity of walking in the community.

The socio-demographic and health characteristics of an older pedestrian population were reported in a study that included the use of face-to-face and telephone interviews to ask questions of the 1249 participants, 72 years of age and older with or without a health problem. [23] Telephone interviews sought to explore participant’s feelings of problems with transportation (driving and crossing by foot at signalled intersections). Face-to-face interviews assessed visual acuity, walking speed and cognitive status. Walking speed was evaluated by getting participants to walk at their usual speed on an 8 ft (2.4m) flat, indoor course. The finding most relevant to the activity of community ambulation was the significant number of participants (99%) who following an evaluation of walking speed could not walk the 1.22m/s required to cross at a signaled intersection in the community of New Haven. However, only 11.4% specifically identified difficulty crossing the street as a concern. Of these, 81% were concerned about insufficient time to cross at an intersection and 78% needed help to cross. The conclusions that can be drawn from this study relevant to community ambulation are that determinants of walking speed in a clinical situation do not equate to walking speed demands in other environments. A gait speed of 1.2m/s is not
reflective of community ambulation [27] as it does not reflect ability in environments where there may be people or vehicular traffic, where crossing situations are different, and distance and gait speed demands are variable. Distances used, such as 8 feet, are frequently insufficient to get far enough in the community to achieve participation needs such as crossing a street or road and are therefore not typical of community ambulation distances. In addition the perception by participants of the need for assistance in ADL tasks and when walking in the community strongly correlated with lower walking speeds. The participant’s need for assistance may be linked to confidence and being less sure about the challenges in the environment when walking in the community. [20] Previous studies have suggested a positive correlation between confidence in activities of daily living and self-perception of walking ability. [24,25]

Another study in London study [26] interviewed 40 clients, 10 months post stroke and after discharge from rehabilitation. The interviews explored ways in which the stroke had affected client’s daily activities including housework, pursuing former activities, bathing and dressing, walking and communicating. This study concluded that clients identified the loss of social contact and valued roles as the most significant change post stroke. Walking was a highly valued pursuit identified by a number of the participants. There was little reference to particular environmental challenges, which does little to enhance our understanding of the unique characteristics within the environment that are obstacles to walking. More concerns were expressed about walking differently and appearing different. In clinical practice it is known that clients value mobility highly as a goal [24,26] but clinicians should acknowledge that a clients perception of appearing different due to their walking behaviour may act as a potential barrier to a return to walking in the community.
Summary

When considering the topic of interest, community ambulation, no one study has identified the aspects that clients find most challenging when returning to walk in their community. The research acknowledges that barriers in the community will restrict an individual’s participation and clients who are less sure or lack confidence limit or curtail trips into their community. However the findings from these studies do suggest that there are a myriad of influences on community ambulation such as the size type and layout of the community that place unique demands on the skill requirements of walking in the community. [28, 29] The following section will explore evidence from the literature of the unique demands of ambulation in a rural community.

Search Three Results

Ambulation in a rural community

Rural environments have long been assumed to place different constraints on the ability of individuals to access services. An individual with a disability living in a rural or remote community is often considered to be at a “double disadvantage” whereby those with a disability (physical limitations) who live in rural or remote communities (geographical limitations) experience added disadvantage by living with a disability outside a major urbanized centre. [30]

In a study of individuals with a disability living in rural and remote NSW (Australia), researchers interviewed clients with a range of disabilities across a range of ages. [30]
The major themes that emerged as impediments to living in a rural or region community for a person with a disability were distance from services, inappropriate location or lack of services, poor education or employment opportunities and inadequate technological support. However this study also commented on the advantages of living in a rural or remote community for a person with a disability. These included a strong sense of community and respect, a greater sense of belonging and the willingness of neighbours to help. In the context of a return to ambulation in a small rural community, community connectedness or a sense of belonging and emotional connection [31,32] may facilitate walking outside the home and in the community thereby enabling ongoing participation and enhanced quality of life.

Demands of ambulation in a rural community.

Three (3) studies were found that explored the unique community ambulation requirements of rural communities [33, 34, 35]

For rural residents in a Swedish community the ability to access and use transport was a key priority. [33,34] These studies evaluated the occupational therapy activity of daily living (ADL) staircase and the rating of items and their relevance to the perceptions of key areas of independence in a cohort of elderly subjects in a rural community. Transport in the ADL assessment scale was defined as the ability to get to a stop for transportation and to get onto and off a bus. However for patients in a rural community the lack of public transport was the most limiting factor. For patients from a rural setting the order of the sub-scale was revised so that the greatest limitation to activities of daily living, transport was weighted more heavily. The revised ADL scale was used in a rural cohort of elderly with osteoporosis. [34] The inability to get to a
parking area and getting into and out of a car was the most “dependent” item. An inability to go shopping as defined by going to the store, managing stairs /obstacles, carrying groceries and taking them home was seen as the second most significant functional limitation for those individuals. This finding highlights two aspects. Firstly the significant activity limitations that can arise from environments either rural or metropolitan that do not cater for the needs of people with a disability and secondly the different priorities that client may have and the destinations that they choose as important when accessing their community.

Quality of life tools such as an activity of daily living index can inform about the clients perceptions but objective evaluations of the unique demands of rural environment on community ambulation are also useful. The specific requirement of gait speed and distance in rural communities (USA) as compared to urban communities has been evaluated. [37] The researchers selected the sites that were viewed as the most common for individuals to visit. These included supermarkets, chemists, banks, and department stores, post offices and doctors rooms. A previous researcher had selected these sites as commonly accessed destinations. [29] Seven communities of different size were compared. Two rural centres, three small towns and three cities were evaluated. This study revealed that the distances and speed of gait varied widely between sites. Rural communities (pop < 10,000) have shorter distances to walk to commonly used locations such as the bank, (15 metres) or the chemist (11.5 metres). As the population density increases the need to walk faster and walk greater distances also increased. For example in the smaller community (<10,000) gait speed at a signalled intersection was on average 44.5 m/min (.74m/s) and in the larger centre (>95,000) it was 63.5m/min (1.06m/s). The greatest mean
distance required to walk for any community destination was in the population centre of greater than 95,000 where subjects had to walk 342 metres to the supermarket. In communities of less than 10,000 the mean distance required to walk to the supermarket was 230m and the department store 132m. Curb height differed only by 1.5 cm between the smallest community and the city (>95,000). Curb height is acknowledged as important in training but not a major variable affecting community ambulation. [28,36] This finding of community differences is analogous to that made in a study of housing estates (old, mature and new) in Singapore where the age of the estate affected the distance required to walk between commonly used destinations with distances averaging 240m in the old estates to 439m in the newest estates. [37] Whilst this study was not conducted in a regional or rural community it suggests that the age of the community may be a consideration based on unique design or architectural features such as the proximity and layout of facilities, the height of curbs or the number of steps. The clinical value when preparing a client for discharge is the consideration of the client’s community destinations that enable activities of daily living. [20,36] When determining the walking distance and speed requirements required for independent community ambulation the size of the community should be considered, as the traffic and pedestrian demands may vary. This is important for therapists who practice in a rural or regional setting to acknowledge, and who are involved in the discharge planning of clients back to their rural or regional community. The age of the community may also be a consideration as architectural features of period design such as the type of paving used in the streetscape and the depth of the curb side gutters can differ. [37]

Summary
There is little information on the particular community mobility requirements of rural communities. Much disability research is urban centric and discussions about assisting individuals with mobility problems in these communities makes assumptions about the presence of informal family networks to supplement a client’s mobility needs and the availability of government and non-government services such as taxi or community transport and public transport. [38,39] The research cited has illustrated that communities do differ in their community ambulation requirements and that the priorities of individuals within communities also differ in the context of what their specific participation needs are. However, the participants’ view of what community ambulation means to them and the environments that are most significant to them are explored superficially or not at all and highlight the inadequacy of the research that explores the patient’s perceptions and decisions about walking in their community.

**Discussion**

Consideration of the environment is key to the successful return to walking in the community of clients with mobility problems yet little literature has been found to guide physiotherapist’s decision making about preparing a client to return to walking in the community. The environment is only one contextual factor in models of disablement. An individual’s participation in their society is also a result of the interaction between their personal characteristics such as age, gender, social and cultural background and his or her environment. The influence of these personal characteristics may vary from one individual to another yet the factors that influence a person’s decision to or perception of their ability to return to walking in their community are unclear. The available literature has been reviewed to explore client’s perceptions about returning to walking in their community with a further emphasis on
potential differences that may exist between regional, rural and metropolitan communities. Barriers to a clients return to walking in their community include a lack of confidence and inadequate assessment of the specific needs of community ambulation. Future research in this area can illuminate therapists understanding of the elements intrinsic and extrinsic to the client that influence community ambulation.
Reference List


[34] Iwarsson S. Environmental influences on the cumulative structure of instrumental ADL: an example in osteoporosis patients in a Swedish rural district. Clinical Rehabilitation 1998;12:221-7.


<table>
<thead>
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<th>Study</th>
<th>Sample Description</th>
<th>Method Description</th>
<th>Evaluation level as compared to the domains of the ICF</th>
<th>Community Type and Size</th>
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<td>Lord et al., [20]</td>
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<td>FAC, RMI 10 metre endurance test on a treadmill over 300 metres Distances can walk (Q3) Use of aids (Q4) Does degree of assistance required to get out and about cause problems for carers (Q5)</td>
<td>Importance of getting out of the home (Q1)</td>
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<td>Max of 3 places indicated by participants (Q2) on the questionnaire (6 items)</td>
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<td>Logan et al., [21]</td>
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<td>Nottingham Extended Activities of Daily Living Index,</td>
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<td>Langlois et al., [23]</td>
<td>1249 elderly with or without a health problem &gt; 72 years and over</td>
<td>Face to face interviews and testing, telephone interviews</td>
<td>Cognition, Visual acuity Walking speed Challenges crossing at signalled intersection eg time to cross</td>
<td>New Haven Connecticut urban population 131,000 (1980)</td>
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<td>Pound et al., [24]</td>
<td>40 participants average age 71 years post stroke</td>
<td>Semi structured interviews</td>
<td>Walking, washing, bathing, housework Leisure activities</td>
<td>Two adjacent health districts in the North Thames Regional Health Authority</td>
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Table 1: Studies that evaluated post stroke client’s perception of the factors that influence walking in their community.